

MEDICAL SCHOOL QUOTAS AND NATIONAL HEALTH

Discrimination That Hurts Us All

LAWRENCE BLOOMGARDEN

THERE is a well-known joke about the boxer who rushes out of his corner at the opening bell only to run into a barrage of punches that leaves him weak and staggering. At the end of the round the fighter stumbles back to his corner and asks his manager, "How am I doing?"

"Great!" the manager replies. "He hasn't laid a glove on you."

Round after round the beating continues, with the fighter being continually reassured: "You're doing great. He hasn't laid a glove on you." Finally, the boxer turns his battered face to the manager and mumbles between swollen lips, "Well, keep an eye on that referee, will you? *Somebody's* beating the hell out of me!"

AMERICA's single most important welfare problem—most authorities have long agreed—is the endangering of the nation's health by a shortage of medical care and particularly of doctors; and this supposedly organizationally ingenious nation has not yet found a way of improving this situation. Worse, we use wastefully the scarce physicians' training facilities we possess: some of the best candidates we have for the all too few places in the medical schools are barred in favor of less fitted individuals. The racist discrimination in admissions policy that every pre-med schoolboy knows exists is, thus, not primarily the problem of those discriminated against: it is a blow against the nation's health. This article is the result of years of study by LAWRENCE BLOOMGARDEN, who, both professionally and as an avocation, has addressed himself to unearthing the tangled roots of this problem since the early 1940's, when he served as case consultant to the Physicians' Committee of the National Refugee Service. Mr. Bloomgarden was born in New York City in 1907, is a graduate of Syracuse University and holds a law degree from New York University. He is on the staff of the Civil Rights Department of the American Jewish Committee, and he has had the benefit of the use of research and other facilities of the Committee in this study.

The unsuccessful applicant to medical school can appreciate the position of the unfortunate pugilist, particularly if the applicant is Jewish. The chances are that he too will never know what or who hit him. He will find himself rejected but may never know the reason why. He will see other applicants, whom he knows to be inferior in scholarship, accepted. He knows of the solemn assurances of the medical schools that discrimination on their part, because of race or religion, is unthinkable. And if he lives in a state which, like New York, has legal prohibitions against such discrimination, he has the added comfort of knowing that his rights to an equal opportunity for a medical degree are protected by law.

Yet, indubitably, somewhere along the line something happens, and our hypothetical applicant finds himself hanging on the ropes and wondering what hit him.

In truth, to stretch the metaphor, it isn't even easy for the spectator to find out what is going on. Numerous, subjective, and shifting criteria for admission to medical schools make the picture a scrambled one and considerable patience and ingenuity are required before the claims, counter-claims, and highly inaccessible statistics can be fitted together into a coherent whole.

The overriding element in the whole medical school picture is the simple fact that not everyone who wants to can become a doctor. Of course not everyone who wants to can become a millionaire, or, for that matter, a chorus girl, either. But there is no conscious, well-organized effort on the part of others to limit the number of chorus girls or millionaires.

For the prospective doctor the case is far different. For even if he has the brains, the ability, and the money, he may not be able to

become a doctor. Of the more than 20,000 qualified applicants who yearly apply to medical schools, only about 7,000 can be accepted. The medical schools can and will take no more. This anomalous situation, where about one out of three qualified candidates for a profession are accepted for training, is in itself a novelty in America, where it is customary to think of careers being open to all who wish to pursue them.

LIMITATION was not always the rule in American medical schools. A half century ago it was possible for almost anyone with a high school education to enter medical school. In 1905, for example, 5,600 doctors graduated from medical schools to serve a national population of 83 million. Not until 1950, when our population had reached the 155-million mark, were as many as 5,600 doctors again graduated in one year. Between those two dates an event took place that virtually revolutionized the medical profession. That event was the Flexner Report of 1910.

The Flexner Report, undertaken through a grant of the Carnegie Foundation, was a devastating indictment of American medical education. It showed that only 82 of the 155 schools then in existence were associated with established colleges or universities; the remainder were privately owned institutions, most of them run for profit, and lacking fundamental equipment for training. Standards were incredibly low compared with European schools. Facilities for clinical training were meager.

The report resulted in the immediate reorganization of medical education in the United States. Most of the weaker schools closed down; by 1927 only 79 had survived. Clinical training on an intensive scale was introduced, and by 1920 the now familiar system of high-grade four-year university schools was well established. American medical schools rapidly became equal to any in the world.

The closing of so many medical schools meant, of course, fewer new doctors. By 1923 only 3,100 doctors were graduated, as compared to almost twice this figure eighteen

years earlier. During the next ten years the number rose and in 1933, 4,800 doctors were graduated.

The relatively slow expansion of approved medical schools after the Flexner Report had knocked out roughly half of the existing institutions may be accounted for largely by the tremendous expense of educational facilities in this field. It costs approximately \$12,000 to train an American doctor over the full four-year period. Of this sum, only about one-fourth is covered by tuition. The remainder must come through private contributions or state aid.

A rough idea of what is involved in the launching of a new medical school can be got by glancing at the prospective budget of the new Yeshiva University nonsectarian medical school. This school will train 100 doctors per year beginning next fall, and it will cost \$10,000,000 just to open its doors, while the completed medical center will come to \$25,000,000. Even in America that kind of money is not easily obtained for non-profit-making purposes. Yet even these prohibitive costs, although they undoubtedly slowed up the necessary expansion of medical schools, would not have halted it altogether. It took a special situation to accomplish that. The "situation" was the depression of the 30's.

By 1933 the depression had badly hurt the medical profession. The \$11,000 average annual income of physicians in 1928 had dropped sharply. Patients by the millions could no longer afford to pay for medical care. The leaders of the profession met this crisis the same way that many leaders of industry, trade unions, and farm groups were meeting similar crises. They cut back on production. After an intensive study, the Council on Medical Education of the American Medical Association came to the conclusion in 1933 that there were too many doctors. It issued a report advising medical schools that the training of physicians should be "drastically curtailed." As has been said, almost thirty years earlier, in 1905, medical schools had turned out 5,600 doctors annually to serve a population of 83 million. Now

the AMA was taking the position that 4,800 doctors per year were too many for a national population of 125 million.

MEDICAL schools did not waste much time in putting this advice into practice. Although actually there was not much of a cutback (less than a 5 per cent curtailment in entering classes occurred from 1933 to 1936), the natural expansion process was halted completely. Since the number of applicants continued to rise with the expanding population of the country, the competition for the available training rose sharply.

Able to pick and choose among the throng of eager applicants, many of the schools engaged in arbitrary and even bizarre methods of selection and rejection. State and municipal medical colleges began severe restrictions on the admission of non-residents. Private medical schools, on the other hand, adopted policies designed, they maintained, to produce a representative geographical "spray" (distribution) among their student body. While these opposing policies might seem to cancel each other out, the actual effect was just the reverse. A large group of candidates were caught in a squeeze whereby they could not get into out-of-state medical schools because they were non-residents, and the local schools refused them because they were residents. Thus, a native of Texas has an even chance of getting into a medical school when he applies. His medical schools prefer Texans. A New Yorker, however, has only one chance in four of being accepted for training. His medical schools also seem to prefer Texans. This makes things fine for Texans, not so good for New Yorkers.

At this point a nasty word must be used. Discrimination was not unknown in the medical profession before 1933. Indeed, in 1931 Heywood Broun's famous book, *Christians Only*, amply documented discriminatory practices in the medical schools. It showed, for example, that in 1927, 80 per cent of the non-Jewish applicants and almost 50 per cent of the Jewish applicants from City College were accepted into medical school, while only three years later the non-Jewish accept-

ance were 74 per cent while the Jewish admittances had fallen to less than 20 per cent.

But there were several factors which served to ameliorate discriminatory tendencies in the pre-depression era. For one thing, total applications to medical schools were only 12,000, of which the schools could accept half. This meant that one out of every two applicants would in any case be accepted. Again, although only 20 per cent of the Jewish applicants of City College gained admittance to American medical schools in 1930, an additional 13 per cent were accepted by foreign medical schools. Both these ameliorative conditions were fundamentally altered by the report of 1933.

THE immediate effect of the AMA report, intended or not, was to produce a sharp reduction of Jewish students in the entering classes of 1934, 1935, and 1936. From 912 in the freshman classes of 1933, the number dropped to 617 in 1936, a reduction of almost one-third.* This clearly met the AMA standard of "drastic curtailment," even though, as we have seen, the over-all reduction of all medical students was less than 5 per cent in the same period. The brunt of the new policy, therefore, was borne almost exclusively by Jewish students. Cuts would seem to have been greatest in Eastern areas where the bulk of the Jewish applicants came from. Thus, in 1932, the College of Physicians and Surgeons of Columbia University accepted thirty-three Jewish applicants, in 1936 only twelve. Four Philadelphia medical schools showed a decline in Jewish enrollment from 103 in 1934 to 58 in 1936.

The AMA in 1933 was not only concerned with the domestic production of American doctors but the foreign as well. As the report of its Council on Medical Education observed: "To permit the large number of applicants who cannot be accommodated in the medical schools of the United States to study abroad and then return here to practice would inevitably lower the standards and corrupt the ideals of medicine."

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This AMA observation was shortly followed by a program designed to have state boards withdraw medical licensure opportunities from graduates of foreign universities, a program which met with at least limited success. Most of the students studying abroad, significantly, were Jewish.*

The rationale for these policies was not neglected, nor left implicit, by the policy-makers. In 1937 and 1938, *after* the pattern of discriminatory admissions had been firmly established, a number of medical educators attempted to justify it. One view, urged by the then secretary of the American Medical Association, himself Jewish, was that the number of Jewish applicants were "overwhelming" American medical schools. Evidently, the difference of less than 300 Jewish students per year between the earlier admissions and those established under the restrictive policies of 1933, out of a total entering class of 6,000, was that between a reasonable and "overwhelming" number.

ANOTHER point of view, advanced by Dean Willard C. Rappleye of the College of Physicians and Surgeons of Columbia University, was that the "representation of the various social and religious groups in medicine ought to be kept fairly parallel with the population make-up." This argument, based on the quota theory of religious and ethnic representation, was the rationale most commonly advanced for discriminatory policies. How the theory operated in practice was graphically explained by Dean Ladd of the Cornell Medical School in a letter of 1940. He wrote: "Cornell Medical College admits a class of eighty each fall. It picks these men from about twelve hundred applicants of whom seven hundred or more are Jews. We

limit the number of Jews admitted to each class to roughly the proportion of Jews in the population in this State, which is a higher proportion than any other part of the country. That means that we take in from 10-15 per cent Jews. The same qualifications hold in picking Jewish students as in picking Gentile students; that is, they are judged not only on the basis of scholarship, but on character, personality, leadership, etc.

"Mr. ———— had a number of good qualities, but in the opinion of the Admission Committee there were a number of Jewish applicants who applied to the Medical School who surpassed him in desirability."

In other words, Jews and non-Jews were rated on separate scales. According to the Dean's figures, 700 Jews and 500 non-Jews on an average applied every year. Of this number, approximately 10 Jews and 70 non-Jews were selected. A Jewish applicant to Cornell, therefore, had one chance in seventy of acceptance, a non-Jewish applicant, one in seven. In effect, this meant that many "A" Jewish students would be turned down, while "B" and "B—" non-Jews made the grade—a situation hardly of service to the medical profession or its patients.

The whole quota policy was once known under the less delicate term of the *numerus clausus*, instituted in Poland and other East European countries on openly anti-Semitic grounds. From almost any point of view, the argument in favor of quotas has been found lacking in logic, fairness, or good sense. It is manifestly subversive of the democratic ethic that citizens be treated and judged as members of racial, religious, or national blocs, and not as individuals. It is clearly an argument of convenience, never used to justify expansion of opportunity for minority groups, but only for limitation. It is never said, for example, that Negro medical students should constitute 10 per cent of the total to correspond to the Negro percentage of our population; nor is it ever argued that Jewish executives in banks and insurance companies, two fields in which Jews are poorly represented on the administrative lev-

*Traditionally, of course, many European medical schools, particularly in pre-Hitler Germany and Austria, and in Switzerland, had the reputation of having *higher* medical standards than American schools. By 1933 it is probable that the gap separating the medical standards of the two continents had largely disappeared, but this was the first time that a responsible American medical group had suggested that European schools were *inferior* to ours.

el, should equal 4 per cent of the total to correspond to the Jewish percentage of the American population.

A GREAT deal has happened, of course, since Dean Ladd's letter of 1940. For one thing, it is no longer good form to justify or even admit discrimination. For another, several states, including New York, have laws specifically prohibiting such practices.

Another factor in the modern medical picture is the acute national shortage of physicians which became obvious at the end of World War II. Medical educators themselves estimated in 1945 that 20,000 more physicians were badly needed, and the report of the President's Committee on Health Needs of the Nation indicates a prospective shortage of 30,000 physicians by 1960.

In the face of these clear needs, the AMA seems to have revised its earlier views on the overproduction of doctors. In June 1951 it announced that "it has no desire to limit the production of properly trained physicians to serve the American people." And it emphasized its willingness to encourage the expansion of medical training facilities. The AMA has also reversed its attitude toward foreign medical schools. State licensing boards have been urged that graduates of foreign schools "be accorded the same opportunities for licensure as graduates of approved medical schools in the United States." It should be noted, however, that the Council on Medical Education, in its 1952 report, observes that "opportunities for American students to obtain a medical education in the better foreign medical schools are diminishing." The medical schools in Great Britain, for example, are now accepting very few Americans because of their own need for more doctors.

This combination of changed public attitudes, new state laws, and an acute shortage of doctors has brought some important changes in the techniques of admission by medical schools. "Techniques" is the correct word here, for the aims, and the results, would appear to be about the same. The Jewish applicant still too often finds himself on

the outside, a victim this time of one or another of current admissions criteria.

THE problem of criteria is worth some investigation because the medical schools rest their whole case upon it. The dialogue generally begins when a rejected Jewish applicant notices that other applicants, with grades lower than his own, have been admitted. He wants to know why. He is told that personality factors have also been considered. If he has applied to Flower Hospital Medical School in New York he learns that his "diction, voice, physical appearance, grooming" have all been weighed. This information may not make him happier, but it certainly discourages him from pursuing the investigation further.

Admittedly, such personality factors as "diction, voice, physical appearance, grooming" may contribute to the well-known bedside manner and therefore to the average doctor's success. But a pathologist or research worker may go through his entire career without ever seeing a live patient, while a surgeon who leaves a sponge or a clamp inside his victim would need an unusual bedside manner indeed to mollify his outraged patient, or placate the bereaved family. And when one considers the personalities of some outstanding pioneers in medical history, and finds that a frequent common characteristic is a kind of pig-headed obstinacy, a quality seldom associated with a sunny disposition but very useful in overcoming the opposition of eminent fools, it is cause for thanksgiving that men like Ehrlich, Koch, and Freud did not need the assent of the Flower Hospital Admissions Committee in order to study medicine.

Sir William Osler, the great English diagnostician, once said: "There are only two sorts of doctors; those who practice with their brains, and those who practice with their tongues." The Flower Hospital admission requirements would seem to favor the second.

Even when personality criteria are not used as a conscious—or unconscious—cover for prejudice, objective evidence seems to cast great doubt on the worth of such criteria for ad-

missions. The Menninger Clinic in Topeka, Kansas, has recently been studying methods of improving the selection of physicians for psychiatric training. Teaching psychiatrists gave intensive interviews to the candidates and then rated them as to probable aptitudes. No applicants were excluded by this process, the sole purpose being to determine the value of personality interviews in selecting physicians for the training program. Comparison between the performance of the candidates and their interview ratings with *trained psychiatrists* revealed a correlation of only +.2. This is only slightly better than the interviewers could have done by flipping a coin. Seven out of the ten top trainees, rated on performance at the conclusion of the training, would have failed to qualify if results of the personality interviews had been used to bar candidates.

Obviously, physicians on admissions committees do not have the competency of trained psychiatrists in judging personality qualifications. Yet they have not hesitated to use these subjective criteria in deciding who shall and who shall not enter medical school. And when the record of Flower Hospital shows, as it does, that Jewish applicants are rejected three and a half times as often as non-Jewish applicants of comparable scholarship by these personality criteria, the inference is overwhelming that the admissions committee is concerned not with personality but with something very different.

Geographical criteria may constitute a legitimate admissions requirement where some private medical schools wish to establish a national character. As for state medical schools maintained with tax funds, they are under obligation to prefer residents. Yet geographical criteria are only legitimate where they are fairly and scrupulously administered. In New York, private medical schools use highly elastic geographical criteria for reasons which are at least dubious.

In 1950, the New York State Department of Education studied the admissions practices of nine medical schools in the state. The study threw grave doubt on the real purpose of geographical criteria in some of these

schools. It was discovered, for example, that non-Jewish residents of New York found it just as easy as non-residents to get into private medical schools. Only Jewish residents found it more difficult to get into such schools—ostensibly because they were New Yorkers. It appears that geographical criteria are indeed used—but only if the applicant is Jewish.

The study also showed that more than 30 per cent of the Jewish applications whose grades on a comparative basis should have entitled them to admittance to some school failed to get into any medical school in the state. This figure of rejections would have been much higher had it not been for the liberal and eminently fair admissions policy of two of the nine schools, New York University and the State University at Long Island Medical College. These two accounted for more than two-thirds of all the Jewish medical students in the state. The other seven showed a sharp distortion in the proportion of Jews to non-Jews accepted on a comparative scholarship basis.

JUST what happens when a medical school is free to juggle these various criteria may best be understood by a brief case study of Cornell University Medical School's admission practices.

Cornell follows a declared policy of limiting the number of students it will accept from any one preparatory school. It distributes its 80 available places among an average of twenty-five colleges. Most of the pre-medical graduates of New York University, Columbia University, Syracuse, and the City Colleges of New York are Jewish. By limiting admissions to one student each from NYU, Syracuse, and City College, and two from Columbia, Cornell can dispose of as many as 200 Jewish applications with one or two acceptances. Since the graduating class of each university usually contains a sprinkling of closely bunched top-grade students, if only one or two are chosen from each school it is possible to weed out Jewish applicants rather easily without too obvious discrimination in any particular case. Only when an over-all analysis discloses that non-Jews are

chosen over Jews of comparative scholarship on an eight to one ratio, does it become clear how such a system operates in practice.

An even stronger indication that Dean Ladd's admitted 10-15 per cent quota of 1940 is still in force today comes through an examination of Cornell Medical's treatment of applicants from Cornell University itself. Here, the question of school could not be a factor since all applicants came from the same one.

The 1950 study showed that 20 pre-medical graduates of Cornell University were accepted into Cornell Medical School out of 64 applicants. Twenty-nine of these applicants were Jewish, 35 non-Jewish. Although the average grades of the Jewish students were about 10 per cent higher, the acceptances were in inverse proportion to the grades on a group basis, with 5 Jews and 15 non-Jews admitted.

The Department of Education study of Cornell admissions policy included personality evaluations for each applicant from at least three faculty undergraduate advisors. These evaluations, based on the teacher's appraisal of the student's aptitudes for medicine, were combined with the scholarship grades to provide an over-all average for each student. The personality evaluations of the Jewish students tended to be much lower than those of the other students, probably a reflection of the advisors' pessimism on the Jewish applicants' chances of getting into medical school. However, on the basis of the joint averages of scholarship and personality, there were 18 Jews and 18 non-Jews who qualified as either "superior" or "good." This over-all evaluation predicted with almost complete accuracy the fate of the non-Jewish "superior" and "good" applicants, 15 of whom were accepted. Yet it failed miserably to foretell the fate of the 18 Jewish students, only 5 of whom were accepted. Evidently, factors other than "personality"—vague as that criterion is—or scholarship, are important when applying to Cornell Medical School.

Conceivably, a defender of Cornell's admissions policies might contend that the desire to get a broad geographical distribution

of students, and not discrimination, was important, since most of the Jewish applicants came from New York City. This contention does not stand up under examination. Cornell Medical School appears to have no consistent pattern of acceptances for New York City residents. In 1949, it accepted thirty from New York, in 1950, fifteen. A variation of 50 per cent in consecutive years precludes geography as an important factor in admissions policy.

HERE a delicate question must be raised. Cornell, after all, is in New York State and New York has had an Education Practices Law since 1948 designed to eliminate just such policies. To put it mildly, something would seem to be amiss in the enforcement of the law.

Actually, the responsible state authorities have not been blind to these violations. Certain measures have been taken evidently aimed at correcting such abuses. Yet these have clearly not been enough.

Already mentioned was a 1950 study of medical school admissions practices by the New York State Department of Education. This study itself is a curious hodge-podge. It contains all the facts and raw data necessary to establish probable "unfair education practices"—the requirement under the New York State law. Yet it never analyzes or assembles this data in any meaningful fashion and, above all, it shies clear of judgments and conclusions. Instead, it is satisfied with the mournful statement that, "While the data in the survey establish conclusively the existence of differential rates of acceptance for various groups of applicants, it is less certain to what extent this differential should be interpreted as discrimination, since it is impossible to determine how much of the differential can be accounted for by the operation of factors of legitimate nature, such as residence or type of undergraduate college."

The same analyst, however, held a different opinion at an earlier stage of the study as to what proof was needed. In the planning stage he observed that discrimination is established by showing a statistically signifi-

cant difference in treatment. In any case, it seems incredibly obtuse not to realize that it is precisely the legitimacy of the criteria which such a study must evaluate if it is to have any worth at all. Barring outright confession of discrimination, any case for or against the medical schools must necessarily rest completely on an analysis of these criteria in the light of their effect on the composition of the student body. And in this particular study, a simple transposition of the accumulated data to IBM cards, which was never done, would have automatically disclosed the illegitimacy of the criteria by revealing mathematically the effect of the religious background factor.

An exception to this general criticism can be made. A special analysis for the data pertaining to Cornell Medical School was completed and the conclusion reached that the evidence "strongly suggests that Cornell is using a quota system in admission of Jewish pre-meds." This material was not presented in the final report nor were any steps taken by the Department of Education to compel compliance with the law.

One last, sad fact remains to be told about this unhappy study. It was never released. After conferring with the deans of the New York medical schools, the Board of Regents discovered "defects" in it, and, to the obvious relief of the medical schools, withdrew it. Another study was promised, this time by the Board of Regents.

The Board of Regents study has been concluded and will shortly be released. Preliminary information on its contents are not encouraging. They indicate a discursive, historical treatment of the general problem of discrimination and medical school admissions policies, rather than an incisive analysis of specific schools.

If these rumors are confirmed, it may be confidently predicted that the Board of Regents study will be quickly relegated to the voluminous "file and forget" dossiers of the New York medical schools. Innumerable studies, reports, and articles have been written, and countless high-level approaches to the problem have been made. Many of those

most actively engaged in eliminating discrimination in the medical schools have, by now, reached the conclusion that what is needed today is a mite less stratospheric diplomacy and a few blunt attempts to have the law enforced. Certainly the facts seem clear enough, and although there is an understandable reluctance to offend the sensibilities of the medical educators, the fact remains that the medical people have shown themselves to be remarkably insensible to the feelings of others.

Unfortunately, the restrictive admissions practices of New York medical schools are by no means unique. Although the greatest problem exists in that state, discrimination in American medical schools elsewhere can be equally documented. Studies of admissions at Pennsylvania medical schools, for example, show similar practices.

It is a cliché that discrimination hurts everybody, but in medicine it can be demonstrated almost mathematically. The possible contributions of those high-caliber students who have been barred from medical school by discriminating quotas must remain, of course, matters of conjecture, but the actual contributions of Jewish physicians who obtained their degrees only because of the more liberal policies of foreign medical schools are on the record. The many outstanding doctors in this category stand as effective rebukes to existing criteria of selection. The assistant director of research at one of the largest cancer hospitals, who has made significant discoveries in the field; the young doctor at Seaview Hospital who has played a leading part in developing and testing, the new anti-TB drugs; a brilliant psychobiologist at Creedmore State Hospital who has done pioneer work in disclosing the relationship between mental disturbance and organic brain pathology, thus opening up the possibility of treating neuroses and psychoses by medication, surgery, and other direct methods; a doctor who has made major contributions to research on the cellular structure of aging persons in the new field of medicine called gerontology—through

which techniques of prolonging life are now being sought—foreign med schools found room for these men after American schools had turned them down. Yet it is a sobering thought that, today, these four doctors, among many others of similar caliber, could probably not obtain a medical education, for the foreign opportunities have been severely curtailed. One wonders how many like them have been turned away from a medical career.

Nor is there any evidence that present interview techniques and personality criteria are even successful in eliminating the emotionally unstable among prospective doctors. Indeed, what evidence there is would indicate the contrary. A study in 1942 of medical students at Cornell, Illinois, and Chicago revealed that about 25 per cent were in serious need of help for various emotional problems or psychiatric disabilities. And in a recent study by Edward A. Strecker and colleagues, of a senior medical class, 46.5 per cent were found to have neurotic handicaps of major character. Facts such as these impelled the American Psychiatric Association at its recent Conference on Psychiatric Education to urge the rapid development of objective indices for measuring the emotional stability and psychological fitness of medical candidates, to replace the hit-or-miss methods of present admission boards. And it is worthy of note that the conference concluded that "for the present, grades are probably the best single criteria for admission since . . . we do not know as yet what special qualities make a good medical student or a proficient physician, and thus do not have other criteria."

The moral or practical case against discrimination in medical schools need not be labored here. It has been found to lack any justification whatsoever apart from that of protecting vested interests at the expense of the health and welfare of the nation. Yet even those who admit the fallacies of quotas will sometimes refer to the "disproportionate" Jewish interest in medicine. This point needs no refutation, only comprehension.

THE interest of Jewish students in medical education is, of course, a fact. The in-

terest of Italians in the opera is also a fact. The particular talents and interests of ethnic or cultural groups have always served to enrich mankind and, particularly in the United States, have traditionally been seen as forces to be encouraged and nurtured. Jews of genius like Maimonides, Amatus, Ehrlich, Wasserman, Freud, and Schick, to mention only a few, have made inestimable contributions toward the prolongation of human life and the alleviation of suffering. Maimonides' daily prayer of a physician, which reads in part, "May there never develop in me the notion that my education is complete, but give me strength and leisure and zeal continually to enlarge my knowledge," expresses the thirst for knowledge that has traditionally motivated so much of Jewish interest in medicine and other sciences. Even today it is significant that about half of the articles in the various American medical journals which provide new knowledge in the field of medicine are written by Jewish physicians. Yet this admitted Jewish interest in and aptitude for medicine is being deliberately thwarted by a policy of drastic curtailment.

Undoubtedly, the interest of able young Jews in medicine is accentuated by lack of opportunity for them in many other attractive pursuits. So long as the junk business rather than steel, and the loan business rather than banking, are the choices available, enthusiasm for rewarding professions like medicine will be great. This simply illustrates the unbalancing effect on the whole economy of discrimination in any particular field. The tragedy is that the medical profession, which serves the nation so directly, should work to strengthen discriminating tendencies in American life instead of combating them.

The larger tragedy is that the medical educators responsible for recruiting new members to the profession should be selecting them on grounds of prejudice, not competence. As a result, our doctors are not as good as they should and could be. So while prejudice in medicine hurts Jews directly, it also hurts everybody else indirectly.